**REFERRAL FOR SCHOOL-BASED MENTAL HEALTH (SBMH) Services**

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| School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School System: Lee County Schools 041 | | | | | | School Unique ID # (4 digit – assigned by State Ed Dept.): | | | | | |
| \*MH Therapist: | | | | | | SSID# 10 digit number State # found in Powerschool: | | | | | |
| Student Being Referred: | | | | | | Reason for referral: | | | | | |
| DOB: | | | | | | Age: | | | | | |
| Teacher: | | | | | | Grade: | | | | | |
| Exceptionality (or N/A): | BIP:  ☐ Yes ☐ No | | | Race: | | Sex: | | | \*MH Record # (If Accepted into Services): | | |
| Date of Referral: | | School Personnel Making Referral: | | | | | | | Regular Ed: ☐ | Special Ed: ☐  If SPED, Case manager and contact info: | |
| **Insurance Info:** | | | | | | | | | | | |
| Policy held by: ☐ Parent | | | | | | ☐ Legal Guardian | | | | | |
| Name:  Policy Number: | | | | | ☐ Medicaid | | | ☐ All Kids | | ☐ Other | ☐ None |
| Student lives with Parent/Guardian? ☐ Yes ☐ No | | | If not, explain: | | | Student’s Home Address: | | | | | |
| Parent Guardian Name: | | | | | | | Parent/ Guardian Phone Number: | | | | |
| Parent/Guardian notified of referral by School Personnel and agrees to screening for MH services? ☐ Yes ☐ No | | | | | | | | | | | |

**CONCERNING BEHAVIORS (CHECK ALL THAT APPLY)**

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| ☐ Reports Abuse | ☐ Victim of Crime/Violence | ☐ Suicidal Behaviors/Threats |
| ☐ Recent Traumatic Event | ☐ Peer/Social Problems | ☐ Parent/Child Conflict |
| ☐ Unusual Changes in Mood | ☐ Eating Problems | ☐ Substance Use Problems |
| ☐ Withdrawn/Depression | ☐ Recent Loss or Separation | ☐ Excessive Crying/Sadness |
| ☐ Angry/Agitated | ☐ Violent Outbursts | ☐ Fighting/Destroying Property |
| ☐ Resistant to Authority | ☐ Legal/Court Problems | ☐ High Risk Behaviors |
| ☐ Sexual Misconduct | ☐ Bullying (Perp./Victim) | ☐ Reports Sleep Problems |
| ☐ Inattentive/Hyperactive | ☐ Changes in Grades | ☐ Reports Fears/Phobias |
| ☐ Anxiety/Excessive Worry | ☐ Strange/Bizarre Behaviors | ☐ Reports Hallucinations |

Notes:

☐ Referral Accepted ☐ Referral Denied Reason for Denial:

Date Accepted/Denied:       Date Services Started:       Date Services Ended:

\*Items in blue will be completed by the Mental Health Coordinator

***ALL REFERRALS and RELEASES SHOULD BE COMPLETED AND EMAILED TO Layla Ferrell***